



Beri Eye Care Associates, PC

Name _____
Last _____ First _____ MI _____
Home Address _____ Apt # _____
City _____ State _____ Zip _____
Home Phone # () _____ Alternate Phone # () _____
Work Phone # () _____

Date of Birth _____ Age: _____ Sex: M _____ F _____
Occupation _____ Employer _____
Social Security # _____ Marital Status (circle one): M S W D
Responsible Party (circle one): Self Spouse Parent Guardian Other
Name _____ Home Phone # () _____
Address _____ Work Phone # () _____
City, St, Zip _____ Alt. Phone # () _____
Primary Care Physician _____ Office Phone # () _____
Referred by _____ Do you have vision insurance? YES _____ NO _____
Do you participate in an HMO / PPO that requires a co-payment? YES _____ AMOUNT _____ NO _____

Primary Insurance Co. _____ Secondary Ins. Co. _____
Name of Insured _____ Name of Insured _____
Insured DOB _____ Insured DOB _____
ID Number _____ ID Number _____
Group Number _____ Group Number _____
Vision Insurance _____ (If different from above)

Emergency Contact _____ Relationship _____
Phone # _____

I hereby authorize the above physicians to furnish to the above insurance company, primary care physician and other entities related to my health care, all information that may be requested concerning my present illness or injury. I understand my insurance coverage is a relationship between myself and my insurance company, and I agree to accept financial responsibility for payment for charges incurred.

Signature _____ Date _____